Injured Employee's Report of Injury

*A report of accidental injury was submitted by your employer. Payment of disability compensation and/or medical expenses will be considered **after** this completed form and other information are received.*

1. Full name of injured employee:_____

2. Employee's address:_____

3. Telephone: Home: (_____) _____; Work: (_____) _____

4. Employer/Agency: _____

5. Job Title:_____ Employee ID # or SSN:_____

6. Date and time of accident: _____

7. Missed work from: _____ thru _____

8. Date returned to work: _____ If not, expected return to work date: _____

9. Describe the accident: (**What happened, where, how, witnesses**):

_____
_____
_____

10. What injuries were incurred?_____

11. Name/address of attending and/or subsequent physicians or hospitals:

_____
_____

12. Have you received workers compensation benefits before? If so, provide details such as employer, carrier, nature and dates of injuries.

_____
_____
_____
_____

To claim compensation in accordance with Workers Compensation, sign and return this form to:

State Self-Insurance Fund
Division of Personnel Services
Room 951-S-Landon State Office Building
900 SW Jackson
Topeka, Kansas 66612-1251 Tel: (785) 296-2364 Fax: (785) 296-6995

AUTHORIZATION

I hereby authorize and request any physician or hospital to permit a representative of the State Self-Insurance Fund to be furnished a copy of all medical records in connection with any past or present medical treatment associated with this injury. I am willing that a photocopy or fax of this authorization be accepted with the same authority as the original.

Signed: _____ Date: _____